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Sophie Hennekam, Sarah Richard, François Grima

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Article title : Coping with mental health conditions at work and its impact on self-perceived job performance

Authors and Affiliations : - Sarah Richard, EM Strasbourg Business School
-François Grima, University of Paris-East Créteil

Corresponding author : Sophie Hennekamn, Audencia School of Business,
shennekam@audencia.com



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Authors and affiliations:

Sophie Hennekam

Audencia School of Business

8 route de la Jonelière

44312 Nantes

shennekam@audencia.com

IRGO Bordeaux

35 Avenue d'Abadie

Bordeaux, France

Sarah Richard

EM Strasbourg Business School

61 avenue de la forêt noire

67000 Strasbourg

sarah.richard@em-strasbourg.eu

François Grima

University of Paris-East Créteil

60 avenue du Général de Gaulle

94000 Créteil

grima@u-pec.fr

Corresponding author: Sophie Hennekam

Abstract

Purpose: This exploratory qualitative study examines both the impact of mental health conditions on self-perceived job performance as well as how individuals with mental health conditions cope with their conditions at work.

Design: We draw on 257 responses to a qualitative questionnaire and 17 in-depth interviews with individuals with mental health conditions.

Findings: The findings show that mental health conditions can negatively impact self-perceived job performance in the form of lower quality of one's work, slower pace and more mistakes. In addition, the findings reveal coping strategies that positively and negatively affect one's performance at work. Strategies that negatively influence one's performance include substance abuse and self-harm; suppressing and hiding one's symptoms; and forcing oneself to continue to work when feeling unwell. Coping strategies that tend to positively affect their performance include accepting one's condition and taking time off; medication and counselling; mindfulness activities; transparent communication; humor; and a compensation strategy.

Originality: A growing number of individuals struggle with mental health conditions at work, impacting both organizations and employees. However, little is known about the influence of mental health conditions on one's performance at work; how individuals cope with their mental health conditions at work and what effect those coping strategies have on organization-relevant outcomes.

Keywords: mental illness, mental health, mental health conditions, coping, coping strategies, job performance.

Introduction

The American Psychiatric Association (APA, 2018), defines a mental health condition as a condition that involves changes in emotion, thinking or behavior (or a combination of these) that are associated with distress and/or problems functioning in social, work or family activities. Despite the rising number of individuals dealing with mental health conditions in the workplace (Weissman *et al.*, 2017) and the negative effects of such conditions for organizations (Collins *et al.*, 2011), surprisingly little is known about how individuals with mental health conditions navigate the workplace (Elraz, 2018). While such individuals have received a great deal of attention in health-related disciplines, the fields of management and organizational psychology are lagging behind (Follmer and Jones, 2018).

Studying mental health conditions at work is important for several reasons. Firstly, mental health conditions are costly, both in a direct way in the form of being unable to work and having to rely on government income support (Heffernan and Pinkilton, 2011), as in an indirect way through a loss of productivity or sick leave (Levinson *et al.*, 2010). In addition, employers are reluctant to hire individuals with mental health conditions (Dietrich *et al.*, 2014), despite legal recognition of mental health conditions as a disability (Santuzzi and Waltz, 2016). This leads this group of workers to experience lower employment rates compared to the general population (Harris *et al.*, 2014), and when they are employed, under-employment (Levinson *et al.*, 2010) and low wages (Baldwin and Marcus, 2007) are frequent. This is important for individuals with mental health conditions as previous research has found that work improves functioning and recovery by providing structure and stability (Boot *et al.*, 2016), gives meaning and purpose to their lives (Jackson *et al.*, 2009) and thereby improves their general well-being and financial independence (Niekerk, 2009). Furthermore, individuals with mental health conditions can contribute to the workplace in unique ways. Forgeard and colleagues (2016) refer to Positive Beliefs about Mental Illness (PBMI), defined as “perceptions of specific positive qualities, benefits, or advantages individuals

associate with their disorder(s) or symptoms” (p.198). In addition, individuals can also develop some valuable characteristics, such as empathy and resilience that flow out from their mental health conditions (Galvez *et al.*, 2011). For organizations, employing individuals with mental health conditions can also be beneficial in that it improves their reputation, improves the ambiance and culture in the organization and increases loyalty and commitment amongst employees (Peterson *et al.*, 2017).

Having established the importance of mental health conditions in a workplace context, we answer several calls for research on the workplace experiences of individuals with mental health conditions (Elraz, 2018; Follmer and Jones, 2018). While research has documented in what way mental health conditions affect different aspects of their lives (Corrigan and Miller, 2004), little is known about work-related outcomes. In this article, we focus on an organizationally relevant outcome, namely self-perceived job performance, defined as the perception of an individual’s overall performance (Meyer *et al.*, 1989; Meyer *et al.*, 1993).

Moreover, although previous research has identified ways in which individuals cope with the stigma related to their mental health conditions (Ilic *et al.*, 2012), we know little about the way those individuals cope with their condition in the workplace and what the outcomes are of the different strategies they may use. Coping, defined as the cognitive and behavioral efforts made to master, minimize or tolerate stressors (Lazarus and Folkman, 1984), is a relevant theoretical perspective when studying mental health conditions in the workplace (Taylor and Stanton, 2007). To cope with stressful situations, individuals adopt problem-focused and emotion-focused strategies (Lazarus and Folkman, 1984). As mental health conditions can be considered stressors (Ilic *et al.*, 2012) and impact one’s functioning, a coping lens can help us understand how individuals deal with the fluctuating nature of their symptoms and how this relates to work-related outcomes like one’s job performance. Drawing on 257 responses to a qualitative questionnaire and 17 semi-structured interviews, this

exploratory study aims to better understand how employees with mental health conditions deal with their conditions at work using a stress and coping lens, leading to the following research questions:

1. *In what way do mental health conditions affect self-perceived job performance?*
2. *How do employees with mental health conditions cope with their conditions at work?*
3. *Whether and how do those coping strategies affect their self-perceived job performance?*

Literature review

Mental health conditions at work

The Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) lists 157 different conditions. Individuals can be diagnosed with one or several conditions as their symptoms are being observed and assessed by medical health specialists. Mental health conditions have been found to have a negative impact on workplace functioning. For example, research on individuals with anxiety and depression has found that decision-making and risk taking behavior is affected which can be detrimental for organizational performance (Haslam *et al.*, 2005). Moreover, certain types of job performance, such as structured tasks performed under time pressure, are impaired when individuals struggle with ADHD (Biederman *et al.*, 2012).

Workplace adaptations or accommodations, commonly defined as ‘changes to the work environment that allow people with disabilities to work safely and productively’ (Equal Opportunity Act, 2010) exist to help individuals with mental health conditions meet the demands of their job. So-called reasonable accommodations are compulsory in many countries such as the United States (Nardodkar *et al.*, 2016). Despite such legislations,

employees do not always receive accommodations (Wang *et al.*, 2011). However, when they are being provided, such adaptations in the form of flexible work options, the possibility to work from home, quiet workplaces, counselling services or fewer interactions with others do help employees with mental health conditions to fully function in their organizations as it improves their well-being and productivity (Mechanic and Olfson, 2016; Villotti *et al.*, 2012).

Theoretical framework: Coping

We can distinguish between different types of coping, such as stigma coping (Isaksson *et al.*, 2018) and stress coping (Dewe *et al.*, 2010). This study adopts a coping lens, based on Lazarus' and Folkman's (1984) model of stress and coping. This theory is useful in understanding how individuals with mental health conditions deal with their condition (Ilic *et al.*, 2012) and consists of two appraisal processes. Firstly, a potential stressor, the stigma surrounding their mental health condition(s) or the difficulty to meet the demands of work, needs to be perceived as a threat to the self. Secondly, individuals determine whether they have the coping resources in order to deal with the stressor, which leads to different coping strategies. Individuals can cope with work-related demands or stigma by using a variety of strategies, such as doing something about the stressful conditions, thinking about the stressor in a way that buffers its impact, seeking social support, avoiding exposure to or thinking about the stressful conditions (Dewe *et al.*, 2010). Researchers have distinguished between problem-focused coping and emotion-focused coping. Problem-focused strategies seek to fix a problem, while emotion-focused strategies concentrate on minimizing the emotional outcomes of the problem (Lazarus and Folkman, 1984). Problem- focused coping is usually adopted when individuals perceive coping resources to be available, while emotion- focused coping strategies, such as avoidance, might be employed if the stressful event is perceived to be uncontrollable. One type of coping strategy is not inherently better than another. Research typically finds positive and negative relations between problem- and emotion-focused

strategies and individual well-being (Sonnentag and Frese, 2003). However, certain coping resources, such as social support, have been associated with more beneficial coping strategies and fewer maladaptive coping strategies, such as avoidance (Bigatti *et al.*, 2010). Common coping strategies used by individuals with mental health conditions, such as secrecy and avoidance/withdrawal seem to be ineffective and more damaging than beneficial (Link *et al.*, 1991). Self-harm and substance abuse have been identified as ways to regulate or escape from one's negative emotions (Vaughn *et al.*, 2015). Similarly, mindfulness (Gratz and Roemer, 2004), humor (Martin *et al.*, 1993) and seeking help in the form of counselling or medication (Mechanic and Olfson, 2016) are types of coping that have been helpful for individuals in dealing with their mental health conditions. The present study builds on those previous studies and aims to identify the ways in which individuals cope with their mental health conditions and how this affects their self-perceived job performance.

Job performance

The relationship between coping and performance is well-established (Tummers, 2016). For individuals with mental health conditions, it has been found that their negative self-image (Soeker *et al.*, 2019), dysfunctional career expectancies, not seeking accommodations that help them perform (Kulkarni and Gopakumar, 2014), and the negative beliefs about the occupational skills of disabled individuals (Cohen *et al.*, 2018) all negatively affect their job performance. Similarly, the stigma attached to mental health conditions negatively affects school performance (Talebi *et al.*, 2016). Overall, mental health conditions, such as depression, seem to show a negative relationship with job performance (Lerner and Henke, 2008). Although it has been argued that the coping strategies adopted by individuals determine the impact of stressors (Dewe *et al.*, 2010), we do not know how the different coping strategies adopted by individuals with mental health conditions relate to their self-

perceived job performance. We focused on self-perceived job performance, as research has shown that the perception of managers or supervisors are often biased by cognitive processes and expectancies that lead to perceptions that do not reflect the actual performance of individuals with mental health conditions (Colella *et al.*, 1997).

Previous research has identified a range of antecedents of job performance, such as a positive psychological climate, transformational leadership (Biswas and Varma, 2012), engagement (Rich *et al.*, 2010), perceived organizational support and job satisfaction (Miao, 2011). We contribute to the job performance literature by studying the relationship between coping strategies and self-perceived job performance of individuals with mental health conditions.

Methods

Our study had two phases: phase 1 consisted of 257 responses to a qualitative questionnaire and phase 2 involved 17 in-depth interviews. In phase 1, we used a qualitative questionnaire, which is a qualitative way of defining and investigating variation in populations using a questionnaire (Jansen, 2010). This type of questionnaire does not aim to establish frequencies or descriptive statistics but aims to determine the diversity of some topic of interest within a given population, in this case the experiences of people with mental health conditions at work. The qualitative questionnaire has been argued to be useful to analyse the lived experiences of individuals (Fink, 2003), which was what we tried to achieve. The questionnaire allowed us to identify themes and this was followed-up by semi-structured interviews to shed light on the way individuals with mental health conditions cope with their conditions at work.

Sample

Participants were recruited using a variety of channels. A mix of networks and professional associations related to mental health/illness as well as social media and forums were used to invite individuals who self-identified as someone with a mental health condition to participate and fill out an online questionnaire using Qualtrics. As a consequence of this sampling technique, it is not possible to calculate a response rate. One selection criterion was that one needed to be clinically diagnosed with a mental health condition: individuals who self-diagnosed were therefore excluded. This was mentioned upfront in the introductory comments of the questionnaire. Moreover, only individuals with chronic long-term conditions were included as it was expected that individuals with one-off incidents would cope differently with their mental health conditions at work. Anonymity was guaranteed and no incentive to participate was provided. For the questionnaire study in phase 1, the sample consisted of 8% of males against 92% of females. This does not reflect society as the World Health Organization estimates that overall rates of psychiatric conditions are almost identical for men and women. Average age was 34.8 years, ranging from 18 to 64 years. Participants lived in different areas in the world. 55% was European, 29% North-American, 11% Oceanian, 3% African and 2% Asian. They worked in a variety of sectors including healthcare, retail, hospitality, administration, customer services and education. 91% reported being diagnosed with more than one mental health condition. It is difficult to determine whether this reflects comorbidity rates in the wider population as estimates vary widely depending on the conditions studied. A wide range of conditions was mentioned when being asked about this through an open question. We later coded them in line with the classification used by the DSM-5. As participants often reported several conditions, the percentages do not equal 100%. This information can be found in Table 1.

Insert Table 1 around here

For the interview study in phase 2, the sample consisted of 12 females (71%), against 5 males (29%). The interviewees were sampled the same way as the participants in phase 1, but were not taken from the sample that filled out the questionnaire. Average age was 39.2 years, ranging from 25 to 60 years. 59% was European, 35% North-American and 6% Oceanian. 53% reported being diagnosed with more than one mental health condition. The demographic characteristics are provided in Table 2.

Insert Table 2 around here

Procedures

The study was conducted after ethical approval was obtained and participants had signed an informed consent form. Our research had two phases.

In phase 1, 257 responses to a qualitative questionnaire were collected. The questionnaire instrument sought detailed accounts of the lived experiences of people with mental health conditions at work. It consisted of 24, mainly open-ended essay questions. Some questions were asked several times in different wordings to ensure reliability. The questionnaire consisted of four blocks of questions based on the existing literature on mental health conditions in a work context: general information about the participant; questions about their functioning at work; questions about workplace adaptations; and questions about their identity and stigma. We report here on the third block: questions about their functioning at work. It should be acknowledged that the themes explored and questions asked have influenced the responses we have obtained. We thus would have had different findings if we had asked a different set of questions. However, we avoided leading questions and paid attention to its formulation and the ethical considerations involved (Hennekam, 2019).

Moreover, we explored both the positive and negative aspects of having a mental health condition at work. The questionnaire was administered both in Dutch and in English. Back-and-forth translation ensured consistency between the English and Dutch versions. The responses to the questionnaires revealed different coping patterns and were used to build an interview guide to gain more insights in the coping strategies of individuals with mental health conditions and how those strategies related to their self-perceived job performance.

In phase 2, 17 semi-structured interviews were conducted. The interviews were conducted face-to-face when possible (seven interviews) and by telephone or Skype for those conducted over a long distance (ten interviews). Most interviews lasted between one and one-and-a-half hours and were held in English, Dutch or French, depending on the preference of the interviewees. All interviews were transcribed and translated into English. An interview guide was used, but in line with our choice for semi-structured interviews, we also let the interviewees elaborate on themes we had not anticipated and were not included in the interview guide. Building on the questionnaires in phase 1, during the interviews we asked questions about their specific coping strategies.

Establishing the trustworthiness of data analysis

We were continually concerned with the issues of validity and trustworthiness. We followed the recommendations of Schwandt, Lincoln and Guba (2007) to ensure data trustworthiness as follows. First, we established credibility by representing the lived experiences of the participants and making sure that our interpretation aligned with the way they had intended it. Second, we assessed transferability, defined as the applicability of the findings into a broader context, by providing thick descriptions of the data and engaging with our assumptions throughout the research process. Third, we assessed dependability, as related to the reliability of the coding process, by independently coding the transcripts. With the aim to reduce error

and bias (Mays and Pope, 2000), we established the inter-coder reliability using Cohen's κ (Cohen, 1960). We exceeded the inter-coder reliability of 0.80 that is commonly used as a cut-off point (Miles and Huberman, 1994). Finally, we dealt with data confirmability, which refers to the extent to which a study can be replicated by other researchers, by being as transparent as possible in reporting our methods and coding procedures.

Finally, our own role in the data analysis should be acknowledged. The researchers self-identify as two females and one male of Dutch and French origin. One of the researchers has a disability. While we aimed to be systematic and transparent in our analysis of the data, some reflexivity is in order regarding the methodological choices we have made throughout this research project. We recognise that those choices likely reflect 'our preferences' (Brown and Lewis, 2011, p. 866).

Analysis

In phase 1, the responses to the qualitative questionnaire were analysed using content analysis (Stemler, 2001) with the help of NVivo software. This analytical approach was chosen in order to identify themes. The different coping strategies and the different ways mental health conditions impact one's performance emerged as the main themes. In terms of coping strategies, both positive and negative strategies emerged from the data. While some coping strategies, such as substance abuse, self-harm, medication, counselling and communication, were expected based on previous research, others were not expected but emerged naturally. Examples are suppressing and hiding one's symptoms, forcing oneself to continue to work when feeling unwell and a compensation strategy in which individuals tried to do more than necessary when feeling well so that they could be less productive when feeling unwell. While we asked questions about their functioning at work, the participants reported on how their mental health conditions affected their job performance in the form of lower quality of one's

work, slower pace and more mistakes. The identification of those two themes, coping and performance, were used to build the interview guide for phase 2.

In phase 2 we conducted and analyzed the interviews. Following Strauss and Corbin (1990), we first undertook complete readings of each case. The analysis involved an iterative process of coding to develop a codebook, which was modified in line with each new case. The analysis evolved from the first-order themes to the broader categories and dimensions in the third and final step (Gioia *et al.*, 2013). During the first step of the analysis, all the responses were read to get a feel for the data. Then, the coding process was started using the themes identified in phase 1. The codebook was constantly modified by adding new codes, creating sub-codes or merging some codes, as the existing codes were tested against each new case. The questionnaire data were included at this stage. In the second step of the analysis and after coding the data, we focused on the connections between the codes and the identification of higher-order conceptual codes, such as the ways in which their mental health conditions seemed to influence their job performance and the labels of the different coping strategies. We moved away from the rather descriptive formulation of first-order codes, where the words of the participants themselves were used, to a higher level of abstraction where meaningful themes were created based on the first-order themes (Strauss and Corbin, 1990). In addition, connections between the different themes and concepts that were conceptually meaningful were explored in order to provide an evocative model of the way in which individuals cope with their mental health conditions at work. In the third and final step of the analysis, we brought the different strategies under two coping strategies: those that positively and negatively affected one's job performance and we bundled the different ways in which their conditions affect their self-perceived performance at work. Our data analysis structure is depicted in Figure 1 below.

Insert figure 1 around here

Findings and discussion

In this section we present and discuss the findings of both the questionnaire and interview data. At the end of each quote it is indicated whether it comes from the participants who filled out the questionnaire in phase 1 or from the interview data in phase 2. Below, we outline in what way their mental health conditions affect their self-perceived job performance, answering our first research question.

How mental health conditions affect self-perceived job performance

The participants mentioned that their symptoms fluctuated and greatly influenced their overall performance, such as the quality of their work and speed of work or service. Around 30% reported being unable to concentrate or stay focused on their tasks as explained by a participant with anxiety, personality, mood and trauma- and stress-related disorders:

The most common is focus - when I am anxious, depressed, triggered, it is hard to focus (participant 142).

Around 30% of the participants reported having varying energy levels, which affected the amount and quality of their work as a participant with personality, anxiety and eating disorders illustrates:

My eating disorder often means I struggle to have enough energy and keep up so I often find it hard to process what people are saying to me (participant 25).

Moreover, around 20% mentioned being slower and forgetful. The following participant with autism-spectrum, obsessive-compulsive, mood and anxiety disorders explained:

I'm significantly slower than other workers as it takes longer for my brain to process things (participant 132).

Similarly, a participant with personality, anxiety and trauma- and stress-related disorders reported forgetting important information that hindered her to fully function and negatively impacted her performance:

I often lost focus on what I was doing. Sometimes I would forget co-workers' names. I had a hard time remembering my schedule and hated when it changed every week (participant 141).

Forgetting things was mentioned by around 15% of the participants. Most participants reported that their performance was affected in multiple ways, as one cashier with personality, mood and substance disorders illustrates:

I dissociated almost constantly, which made it impossible to remember things. My body became numb which made it difficult to bag groceries. I couldn't move fast enough, customers got angry (participant 110).

In addition, the quality of their work was in some cases impacted by their mental health conditions as one participant with mood and anxiety disorders explained:

Punctuality, feeling tired and irritable, paranoid about what customers think of me, quality of my work can be lower than usual when my mind is racing (participant 105).

Their difficulties to focus, varying energy levels, being slow or forgetful all affected their perception of their own job performance as the following participant with mood, personality, anxiety and eating disorders explained:

It was very hard to work while being completely wrapped up in my mind. My illness takes most of my memory, and that causes both long term and short-term effects.

Working with customers is hard when you need to be on your own. I also found it very draining, and even before the end of the day I had felt suicidal. This affected my work.

My work the next day would also be altered because I would anticipate my 'down' feelings (participant 44).

Another participant with mood and anxiety disorders stated:

When you are in a manic state of anxiety or depression, it affects every decision you make, your concentration, your energy levels and for me ...insomnia, so I am exhausted and make small silly mistakes all the time at work (participant 74).

Finally, around 10% reported that they thought they appeared to be less professional as the quote of a participant with mood and anxiety disorders illustrates:

I can be extremely anxious about decision-making, my speech can become muddled and I have hot flushes. Feel like a bumbling idiot at times (participant 102).

We now answer our second and third research questions regarding how employees with mental health conditions cope with their condition at work and how this affects their self-perceived performance at work. More precisely, we outline the different coping strategies that emerged from the findings, distinguishing between coping strategies that negatively and positively affect their self-perceived job performance.

Coping strategies that lead to negative outcomes

Some coping strategies consisted of dealing with their symptoms in ways that would negatively affect their self-perceived job performance. A first strategy consisted of self-harm and substance abuse, as mentioned by 10% of the participants. A woman with mood, anxiety, trauma- and stress-related, personality and eating disorders explained:

Honestly, I usually act impulsively and use a negative coping skill like suicidal behaviors, cutting, drugs, alcohol, escaping the situation (participant 39).

Similarly, a participant with anxiety and personality disorders reported:

I will try to block it out by getting very drunk or self-harm (participant 19).

Finally, a teacher with eating, mood and personality disorders highlighted how it is for her a way to release tension:

I tend to withdraw myself from others around me and use self-harm as a way to gain a release (participant 147).

This aligns with previous research where substance abuse and self-harm was presented a way to release tensions for individuals (Klonsky, 2007). However, this is obviously a destructive strategy that negatively influenced their performance.

A second strategy consisted of suppressing and hiding their symptoms when they played up as mentioned by 80% of the participants. A participant with eating, personality and trauma- and stress-related disorders mentioned:

I suppress it and don't let any of the highs or lows show, so I seem steady and stable to others (participant 150).

While this allowed them to keep a professional image at work, this strategy seemed to be detrimental for their own well-being and negatively affected their performance in the long run. Concealing one's mental health conditions at work implies spending a great deal of attention to ensure that their condition is not revealed (Ragins *et al.*, 2007). The necessary precautions and increased attention required of concealing is likely to detract from an employee's focus on work, resulting in decreased performance (Johnson *et al.*, 2011). The findings seem to suggest that this led them to engage in impression management in order to avoid disclosing their mental health conditions. Previous research has shown that this constant self-monitoring to avoid disclosure leads to increased stress (Smart and Wegner, 2000). As one participant put it:

Lots of faking, dishonesty, sometimes I just have to quit the job, I make up an excuse to avoid work or social situation (participant 130).

However, sometimes their symptoms could not be concealed and they explained they had to find other ways to justify their behaviors, as one participant recalled:

Often if one of my other personalities took over while at work I had to do damage control and claim that I was working on a new play or novel (participant 141).

A less drastic coping strategy that emerged from the data consisted of pushing oneself to continue to work when feeling unwell. Words like *get on* and *push through* were mentioned by 60% of the participants. The following quote from a participant with mood and anxiety disorders sums it up nicely:

If it's not that bad, but bad enough, I just soldier through, it's not like I have another choice (participant 86).

While this might be perceived as a positive, down-to-earth strategy, it seemed to be negatively related to their job performance. As one interviewee with eating, mood and anxiety disorders mentioned:

So you just get on, because you feel obliged to, but the problem is that it'll have repercussions for your own psychological state and the quality of your work. You just know you will be a wreck again and that's because you've pushed too hard (interviewee 9).

They mentioned that they felt they should take time off, but felt obliged to continue. The findings suggest that participants tried to focus on their job and keep busy as this helped them

to get through the day and perform normally. This tended to function as a distraction and sometimes helped to overrule their mental health conditions for a while. However, over time, the participants indicated that they usually had to rest and look after themselves rather than ignore their symptoms and continue work as it negatively influenced their performance at work. This strategy is therefore not sustainable over time. As one participant with a personality disorder explained:

At times you can push through and keep attending work, although you usually discover later that you have made mistakes, forgotten things etc (participant 30).

Coping strategies that lead to positive outcomes

Participants also mentioned a range of coping strategies that seemed to have a positive impact on their self-perceived job performance. Firstly, it seemed that accepting one's fluctuations and taking time off helped individuals. A participant with mood, eating, personality and trauma- and stress-related disorders explained:

I have learnt over the years that if I am having a bad day and allow myself to have that bad day then I will get over it in a few days. Whereas if I fight it then I will be down for a much longer period of time (participant 67).

The findings suggest that taking time off in the form of short breaks or full days off helped them to regulate their symptoms as mentioned by around 50% of the participants. The following participant with a personality disorder reported:

I try my best to do my job but people can see I'm not happy and I get annoyed and angry really quickly and sometimes I just have to go off the shop floor and sit in the toilet for a bit to calm down (participant 8).

This strategy had a positive impact on their performance at work. For example, an interviewee with anxiety and mood disorders said:

It's like, hey, I can do it! I can actually look after myself and get better, I can be a valuable worker. I think it's all related. The better you feel about yourself, the more you can actually do, the better you perform, the better it makes you feel and the quicker you recover (interviewee 15).

Secondly, the findings indicate that medication and counselling were important, as it seemed to help them to reduce their symptoms, feel better and improve their performance and functioning as mentioned by around 60% of the participants. A participant with mood, anxiety, personality and obsessive-compulsive disorders mentioned:

I am on medication to help soften the intensity of fluctuations. However, it's more just trying to ride it out. Music helps, going for walks etc. (participant 15)

Another participant reported:

If I suddenly get worse, I increase my therapy sessions and I have also been on highest dose on medication (participant 32).

Treatment has been found to lead to better performance, higher productivity and fewer sick-related absences at work (Dewa *et al.*, 2011). It is important to note, however, that earlier research found that many employees with a mental health conditions do not ask for treatment (Mojtabai *et al.*, 2011). Such coping strategies were found to be related to higher quality work or services as illustrated by a quote from an interviewee with anxiety disorder:

I feel that when I try to deal with myself by doing sports or going to therapy sessions, this positive attitude spreads around me. It helps me not only to see the bright side of things, but also helps me also at work. It gives me energy and power to just go for it and be a great teacher, give the best of myself (interviewee 5).

Apart from regular mental health services such as therapy and medication, other activities such as mindfulness were frequently mentioned by the participants and seemed to be beneficial, echoing previous studies (Zou *et al.*, 2018). The findings suggest that yoga, sports, music, breathing exercises and other mindfulness practices all helped them to feel better. A participant with anxiety and mood disorders stated:

Usually, I try to do some mindfulness exercises when my anxiety flairs (participant 138).

These positive coping strategies also improved their job performance. For example, the following interviewee with anxiety and mood disorders reported:

It shows that you are in control, that you can manage your symptoms to a certain extent and that actually empowers you. It gives me the feeling that I can have a happy

and productive life, both personally and professionally. It strengthens the belief that I can do my job and be a useful member of society (interviewee 2).

Clear and open communication with their managers or bosses and asking for workplace adaptations seemed to have a positive impact on their performance at work. The findings suggest that simply keeping one's manager updated on how they were doing tended to help to predict fluctuations and could avoid bad surprises for colleagues. A participant with anxiety, mood and trauma- and stress-related disorders mentioned:

One day at a time and I keep my boss informed on how I am (participant 122).

Only few participants communicated on a regular basis with their bosses. In addition, a participant discussed the importance of having a supportive and close team where people help each other out:

I am able to adapt my job a little bit if I feel low in energy. My colleagues are very supportive and we are a close team which helps (participant 61).

Furthermore, the findings suggest the existence of a compensation strategy in which individuals were mindful to build up credit when they were well, so they would be able to use this during difficult periods. This was reported by around 10% of participants. A participant who struggled with personality and mood disorders explained:

When I'm doing good I just smash my work like a boss and build up those brownie points to use when I'm unwell (participant 47).

Similarly, an administrative assistant with a personality disorder stated she did: *as much as I can during positive times (participant 62)*, which is echoed by a participant with an anxiety disorder:

I try to make the best of my good days, and try to survive the bad days (participant 75).

Finally, humor tended to be helpful for around 10% of participants as it allowed them to avoid showing their emotions and seemed to increase the likelihood to get away with uncomfortable situations in which their symptoms had been visible to others as illustrated by a participant with mood and personality disorders:

I act overly humorous or sarcastic to mask I'm struggling and I use humor a lot to cover up changes, mistakes, etc (participant 137).

Previous research found that this strategy helps individuals to control their lives and deal with stressful life events (Martin *et al.*, 1993) and has been identified previously for individuals with mental health conditions as a way to deal with frustration about structural discrimination (Jenkins and Carpenter-Song, 2008). As explained by an interviewee with a mood disorder:

Humor makes it lighter and easier to deal with. By treating it as if it's not a big deal, it becomes less of an issue and therefore helps me to lift my mood and be a better doctor (interviewee 11).

Moreover, it's important to mention that individuals adopted multiple strategies and chose their coping strategies based on situational factors such as whether it was a working day or not and the severity of their symptoms. This confirms earlier research that stressed the importance of matching job resources to job stressors, showing that not all coping strategies are equally effective in different work environments, under various personal circumstances and at different points in time (De Jonge and Dormann, 2006). As one participant with autism-spectrum and personality disorders put it:

I haven't found a cure-all, it's more like having a toolbox of different items and seeing what works in a given situation (participant 107).

To summarize, the findings suggest that mental health conditions sometimes have a negative impact on one's job performance. First, the participants reported to have difficulties to concentrate or focus, have fluctuating energy levels, are slower and more forgetful and, as a consequence, provide lower quality work or services and appear less professional. Second, participants coped with their conditions in different ways. Some had a positive effect on their job performance, namely accepting one's condition and taking time off, medication and counselling, mindfulness activities, transparent communication, humor, and a compensation strategy in which they worked very hard when they were well so they could do less when unwell. However, when participants coped with their condition by substance abuse or self-harm, suppressed or hid their symptoms or forced themselves to continue to work when feeling unwell, this seemed to hold a more negative relationship with their self-perceived job performance.

Practical implications

This study examined the way in which mental health conditions affect one's self-perceived job performance as well as how those individuals cope with their conditions at work. The different coping strategies identified as well as the relationship with one's job performance have some practical implications that are outlined below.

Firstly, we show in what way mental health conditions impact their self-perceived job performance, such as being slower and having difficulty to focus, being forgetful, making mistakes, having varying levels of energy and providing work or services of lower quality. Although mental health conditions can negatively affect job performance, previous research has shown that individuals with mental health conditions might also express particular skills related to their conditions. For example, exceptional calculation and memorisation skills for individuals with conditions in the autism-spectrum (Treffert, 2009) or perseverance for individuals with bipolar conditions (Hayden *et al.*, 2008) could have a positive influence on their performance at work. However, the negative ways in which mental health conditions seem to influence the self-perceived job performance of the participants in this study could lead to or reinforce existing negative perceptions about individuals with mental health conditions (Dietrich *et al.*, 2014). Such negative beliefs might be acted upon by managers and can lead to discrimination (Kirsh *et al.*, 2009). Individuals with mental health conditions are aware of this (Brohan *et al.*, 2014) and therefore tend to conceal their condition whenever possible (Martin *et al.*, 2015). Moreover, they can internalize these attitudes, leading to self-stigma. Self-stigma has been found to impact one's self-esteem, self-efficacy and work-related performance and attitudes (Corrigan *et al.*, 2006). This could possibly lead to a vicious circle in which their mental health conditions negatively impact their performance, leading to negative perceptions about their performance, which in turn results in self-stigma that hinders their performance at work.

Secondly, communication with one's manager about one's condition seems extremely important. This aligns with Chaudoir and Fisher (2010) who found that being open about a stigmatized identity helps to develop greater intimacy, acceptance and understanding and prevents social isolation. Communication is therefore not only important in getting workplace support (Corbière and Lanctot, 2011), but seems paramount more generally in raising awareness about mental health conditions at work (Follmer and Jones, 2018). However, it has also been argued that being completely open about one's mental health conditions makes those individuals more vulnerable to stigma (Bos *et al.*, 2009).

Secondly, individuals with mental health conditions adopted different coping strategies. Those coping strategies can be linked to the stigmatizing nature of mental health conditions as well as the lack of adaptations at work. For example, hiding one's symptoms is probably the result of the social stigma attached to mental health conditions. Similarly, if individuals had workplaces that are adapted to their specific needs, people with mental health conditions probably would have different coping strategies. As a consequence, our findings have implications for organizations with regards to workplace adaptations and the attitudes to and perceptions of individuals with mental health conditions. Regarding workplace adaptations, it is important to realize that small adaptations are usually sufficient to help those individuals function optimally at work (MacDonald-Wilson *et al.*, 2002). For example, quiet workspaces where individuals can calm down or ground when needed could be provided or individuals could wear headphones to reduce the noise around them or be allowed to work from home when possible. In addition, peer support groups have been argued to be key to their recovery (Beeble and Salem, 2009), so support groups at work could be set up to give them the opportunity to meet others who might have similar experiences to exchange and provide support. Regarding the stigma surrounding mental health conditions, managers and co-workers have an important role to play. While we did not interview or send a questionnaire

to managers, supervisors or co-workers, the participants did report on how a hostile work environment and lack of awareness and knowledge about mental health conditions in their workplaces did have an impact on their performance. Managers often do not know how to deal with workers with mental health conditions (Martin *et al.*, 2015). We recommend providing training for managers to acquire the requisite knowledge about mental health conditions in the workplace. This could take the form of teaching them to recognize warning signs (Dimoff and Kelloway, 2018). Without training, managers might incorrectly attribute fluctuating speed or performance to poor work ethic instead of the symptomology of psychiatric conditions (De Lorenzo, 2013). Finally, managers could play an important role by actively supporting individuals with mental health conditions through the provision of relevant workplace adaptations such as allowing short breaks or noise-cancelling headphones for example and by creating an inclusive ambiance at work where open dialogue, respect and recognition for all are key.

Theoretical implications

The findings contribute to the literature on coping.

Firstly, we contribute to the coping literature by showing that individuals adopt coping strategies that are both positively and negatively related to their own perception of their job performance. Both emotion-focused and problem-focused coping strategies were identified. Humor, mindfulness, self-harm and substance abuse, hiding or suppressing symptoms as well as forcing oneself to continue working were all emotion-focused coping strategies that seemed to be negatively related to job performance. This confirms earlier research that showed that avoidance and denial are maladaptive coping strategies that lead to negative outcomes (Yagil *et al.*, 2011). Only humor and mindfulness seemed to be positively related to their performance at work. That mindfulness showed a positive relationship with job

performance can be explained by the fact that it involves acceptance of their situation, unpleasant thoughts and experiences (Smith *et al.*, 2011). This emotion-focused coping strategy highlights that certain things are beyond their control (Carver *et al.*, 1989) which helps them to let things go, buffers the negative impact of their mental health conditions at work and focus on the tasks at hand, improving their job performance. Problem-focused coping strategies included medication/counselling, communication about one's condition, accepting one's condition and allowing oneself to take time off when needed as well as a compensation strategy. This compensation strategy seemed to be effective in that it helped them to perform up to standard, find a way around the fluctuations of their symptoms and allowed individuals not to feel guilty when not feeling well. Interestingly, those coping strategies were all positively related to their job performance. This is important because while we know that mental health conditions can have a negative impact on one's productivity, level of absenteeism and job performance (Lerner and Henke, 2008), we do not know how different coping strategies affect this relationship.

We contribute to the literature on coping and the different coping strategies identified in earlier research by suggesting that problem-focused coping with mental health conditions might be related to better work-related outcomes. This does not align with Folkman and Moskowitz (2004) who have argued that problem-focused coping strategies are more effective when something can be done about the demand, whereas emotion-focused strategies are best when the stressor encountered is largely uncontrollable, as is the case for mental health conditions. More research is needed to further study these contradictory results.

Limitations and suggestions for future research

First, data were collected at one point in time. It would be interesting to adopt a longitudinal research design in order to capture how individuals manage the fluctuations of their symptoms across time and how this influences their functioning at work.

Second, this study focuses on mental health conditions in general, which is problematic as the symptoms as well the severity of the reported health conditions varies. Therefore, the findings do not allow us to say anything about distinct types of conditions, such as mood or anxiety disorders, making generalizations problematic. In addition, we treated autism and ADHD as mental health conditions, while some scholars argue that neurodiversity is a more appropriate, which needs to be acknowledged. Also, given the prevalence of comorbidity, we encourage future studies to further explore how several mental health conditions interact with one another in a workplace context.

Third, while only individuals who reported to be clinically diagnosed with one or more mental health conditions were included in the study, this is still based on participants' self-reports and not on a standardized clinical interview that would have led to higher validity. Moreover, we focused on self-perceived performance, which might differ from their actual performance in the sense that participants, due to their conditions, might have underestimated their contributions or performance at work.

Fourth, it should be acknowledged that no saturation point was reached. The study is therefore exploratory in nature and more research is needed to further examine the way in which individuals with mental health conditions deal with their conditions at work and how this influences their performance and other organizationally relevant outcomes.

Fifth, women were overrepresented in the sample. This potentially impacts the generalizability of the findings to males. Similarly, the different parts of the world are unequally represented, which is problematic as cultural beliefs and national legislation are likely to influence the findings.

Finally, the design of the study does not allow for causal inferences. Moreover, no valid measure of job performance was used. A quantitative research design with valid and reliable measurements of the constructs under study would help to disentangle the directions of the proposed relationships.

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Table 1: Percentages of reported disorders based on DSM-V classification in survey study.

| Mental health condition | Percentage |
|--|-------------------|
| Personality Disorders | 59% |
| Anxiety Disorders | 54% |
| Mood Disorders | 53% |
| Trauma- and Stressor-Related Disorders | 26% |
| Obsessive-Compulsive Disorders | 15% |
| Eating Disorders | 7% |
| Autism-spectrum disorders | 3% |
| Psychotic Disorders | 3% |
| Neurodevelopmental Disorders | 2% |

Table 2: Demographic characteristics of interview study.

| Interviewee | Gender | Age | Nationality | Mental health condition | Function |
|-------------|--------|-----|-------------|-------------------------|----------------|
| 1 | Male | 26 | Dutch | Autism-Spectrum | Sports coach |
| 2 | Female | 31 | American | Anxiety/Mood | Music teacher |
| 3 | Male | 58 | American | Mood | Administrative |

| | | | | | |
|----|--------|----|------------|--------------------------------------|---------------------------|
| | | | | | worker |
| 4 | Female | 36 | Dutch | Obsessive- Compulsive/Anxiety | Cleaner |
| 5 | Female | 38 | Australian | Anxiety | Primary school teacher |
| 6 | Female | 46 | American | Trauma- and Stress- related/Mood | Bookshop |
| 7 | Female | 29 | British | Personality/Anxiety | Engineer |
| 8 | Male | 44 | British | Autism | Programmer |
| 9 | Female | 32 | American | Eating/Mood/Anxiety | Business Analyst |
| 10 | Female | 38 | American | Personality/Mood | Psychologist |
| 11 | Female | 41 | American | Mood | Doctor |
| 12 | Male | 56 | Dutch | Psychotic/Mood/Anxiety | Deliverer |
| 13 | Female | 60 | Dutch | Anxiety | Care provider |
| 14 | Female | 37 | French | Anxiety/Obessive- Compulsive/Mood | Personal assistant |
| 15 | Female | 42 | French | Anxiety/Mood | Designer |
| 16 | Male | 27 | French | Autism-spectrum | Risk manager |
| 17 | Female | 25 | French | Autism-spectrum | Psychologist |

Figure 1: Data analysis structure

